Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

How Do I Bill for Multiple Services?

If multiples of the same procedure are performed on the same day, providers must bill with the appropriate modifier (if applicable) and must bill all the services on the same claim form to be considered for payment.

Completing the CMS-1500 Claim Form

Note: Refer to the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to Physician-Related Services:

Field Number	Instructions
24B	See Section J for correct place of service codes. These are the only appropriate place of service codes.
24D	Enter the appropriate procedure code for the services being billed. See the fee schedule. ***Modifier***: When appropriate enter a modifier from the list found in Section L.
24H	When billing the Department for one of the EPSDT screening procedure codes, enter an **X** in this field.

How Do I Submit Professional Services on a CMS-1500 Claim Form for Medicare Crossovers?

For services paid for, and/or applied to, the deductible by Medicare:

- Medicare should forward the claim to the Department. If the claim is not received by the Department, please resolve that issue prior to billing a paper claim to reduce the possibility of claim denial and the need to resubmit.
- Complete the claim form as if billing for a non Medicare client.
- Always attach the Medicare Explanation of Medicare Benefits (EOMB).
- Do not indicate any payment made by Medicare in field 29. Enter only payments made by non-Medicare, third-party payers (e.g., Blue Cross) in field 29 and attach the Explanation of Benefits (EOB).

Note: If Medicare allowed/paid on some services and denied other services, the allowed/paid services must be billed on a different claim than the denied services.

Exception: When billing crossover claims for Indian Health Services, follow the instructions in the current Department/MPA *Tribal Health Program Billing Instructions*.

What Does the Department Require from the Provider-Generated EOMB to Process a Crossover Claim?

Header level information on the EOMB must include all the following:

- Medicare as the clearly identified payer;
- The Medicare claim paid or process date;
- The client's name (if not in the column level);
- Medicare Reason codes; and
- Text in font size 12 or greater.

Column level labels on the EOMB for the 1500 Claim Form must include all the following:

- The client's name;
- Date of service;
- Number of service units (whole number) (NOS);
- Procedure Code (PROC);
- Modifiers (MODS);
- Billed amount;
- Allowed amount;
- Deductible;
- Amount paid by Medicare (PROV PD);
- Medicare Adjustment Reason codes and Remark codes; and
- Text that is font size 12.